King/Drew Medical Center Workplan Implementation
Summary by Initiative

County of Los Angeles Department of Health Services

Update Through: 4/29/05

Initiative	Overall Progress Update
Governance	Board nominating committee has met and selected nominees. Board orientation program is under development for presentation on 5/9. Quality Committee is selected and plans to meet before 5/9. At the 5/9 meeting, an Operations Committee will be selected and this group will meet more frequently than monthly.
Management/Structure	There is a Cabinet meeting every Tuesday with key executives with CEO, COO, CIO. CFO, CNO and the Chief Information Officer to discus operational issues. Senior Staff meets every Tuesday standing agenda items include HR, Regulatory, IT and a review of the Implementation workplan. Meeting every Thursday with DHS to review and discus operational issues. Minutes are completed for each meeting which includes actionable items and responsibility for follow-up.
Risk Management	Revised Event Notification and Sentinel Event Reporting, Documentation, and Corrective Action policy and procedure. Presented to all AOD, Charge Nurses, Nurse Managers and Nursing Supervisors on 4/21. Roll-out to staff members to begin by 5/1/05. Clinical Assistance Teams are reinforcing the policy and procedure. Mandatory training for use of restraints is being conducted. Key patient policies are being reviewed and revised in the areas of Confidentiality And Release Of Medical Record Information (09-107), Patient Rights And Ethical Issues (03-207), Interpreter/Translation Services (03-256), Patient Access To Medical Records (09-110) and Discharge Policy: Against Medical Advice (AMA) or Left Without Treatment (LWOT) (03-163).
Regulatory	A focused plan to regain accreditation has been developed and is being implemented. This plan incorporates the use of mock surveys and concurrent medical record audits. The mock survey process was initiated on 4/20 and communicated to the Senior Leadership Team on 4/26. The mock surveys will be conducted on a weekly basis, with the results being communicated to Hospital and Medical Staff leadership for follow-up action. The mock surveys are also being used to coach staff on improving patient care and documentation of that care. Issues from the regulatory action plan involving medical staff performance were identified and communicated to the medical administration group, and included as components of an initial Physician Manager Education Program (PMEP) session held on 4/28. Invitees for this session included chairs, department chiefs and residency program directors, and the training session included an overview of the survey process/schedule for the various regulatory bodies and communication of specific medical staff practices that impact accreditation. The report from a CMS survey in October, 2004 was received, and the plan of correction is being prepared for submission.
Performance and Quality Improvement	Concurrent case reviews on all deaths, critical and sentinel events continue. Reviews identifying a need for further route cause analysis are referred as appropriate. Clinical pertinence reviews (concurrent clinical medical record reviews) began this month. Two RNs have been assigned, a total of 8 will be in place within the next few weeks. Their responsibility will be to review the record from a clinical perspective and check for missing documentation by nurses, physicians and ancillary staff; incomplete orders; completion and quality of nursing assessments; missing ancillary reports; illegible handwriting and unapproved abbreviations; documentation of coordination of care; medication and dosage errors; as well as any other clinical issues. The process involves not only reviewing the record and documenting the deficiencies but communicating those deficiencies to the nurses, physician and ancillary staff when identified to correct within the same calendar day. Issues will be tracked using the Plato database and compared with deficiencies present at the time of discharge to assess the success of the program. Trended information by nursing unit, physician, nurse, ancillary department will be available and used to identify process improvement initiatives, employee and physician counseling and credentialing. We will also send the information to the appropriate committees. The clinical pertinence reviews will take place on all inpatient units including psychiatry, Emergency Department and Same Day Surgery. Clinical Assistance Teams (CAT) rotations have been initiated that are identifying and managing issues related to patient care delivery and processes. Quality Committee has been approved by the HAB and membership has been defined. Awaiting further feedback from County Counsel on the amendment of the bylaws to allow for implementation of revised hospital-wide quality and performance improvement structure. Formal revision of the 2004 KDMC Organizational Performance Plan initiated to be completed this month.
Infection Control	The Bloodborne Pathogens Exposure Control Plan, TB Plan, Isolation Practices and Hand Hygiene Policy have all been reviewed and revised based on current CDC recommendations and national practice standards. The Infection Control manager is reviewing the Policy and Procedure Manual for policies that need to be deleted, revised and/or consolidated utilizing the APIC manual as resource.

King/Drew Medical Center Workplan Implementation
Summary by Initiative

County of Los Angeles Department of Health Services

Update Through: 4/29/05

Initiative	Overall Progress Update
Budget	Reconstructing new cost center codes and organization reporting structure needed for eCAPS implementation. Two key managers now attending Congas training that will be needed in the redesign of financial reporting and analysis tools. CAO developing final budget recommendations for FY 05-06.
Productivity	Unit of service statistics and appropriate data sources for many cost centers have been identified. Finance has been working with each area to complete the verification on employees' home cost center assignment. Collaboration with HR is occurring to ensure appropriate home cost center assignment across the hospital is permanently changed in CWTAPPS. Some of the support areas are changing cost center structure for FY 05-06 under eCAPS to align with productivity measurements. Payroll data including productive hours in CWTAPPS and LCS in May and June of FY 04-05 will reflect the new structure. This change is required for implementation of eCAPS and may require restructuring of benchmark data. The time frame of the implementation of productivity monitoring tool may need to be modified to make the efforts coordinated in relation to the scheduled eCAPS implementation.
Space Planning	Overall this initiative is focused on establishing processes for the future and immediate renovation efforts. These efforts are in jeopardy due to lack of funding and the need for BOS to support investments in infrastructure. Failure to obtain the funding will seriously impact our ability to achieve JCAHO accreditation and correct CMS citations. In addition, we are unable to deliver the required services in the current out patient pharmacy space. The space is too small for the number of prescriptions to be filled. We have identified space on the second floor of the Trauma center. This floor however had been designated for Women's Health Services only. The volume of patient visits does not warrant use of all of the space yet using one corner of the floor for all outpatient pharmacy services is politically sensitive. We are awaiting direction/guidance from DHS on how to proceed. The Psychiatry renovation plans are near completion. However, due to the sensitivity of renovation and the possibility that funding will not be obtained, we have not yet initiated discussions with other organizations using portions of the AHF building. These include Drew University, DMH and USC-County. Discussions with medical and hospital staff will occur this week regarding potential OR renovation and interim use of Trauma ORs during renovation period. The challenge is for the surgeons to accept the availability of 2 ORs only during this period which will require strict scheduling guidelines. The timeline for completion of all renovation efforts is now pushed out to 1/06. The state licensing board is not able to meet with us until mid-June and their approval is critical to the OR renovation project. OSHPD has already approved the plans. JCAHO accreditation will be jeopardized if we are not near completion of the OR and Psych renovation efforts at the time of their survey. Further slippage of funding approval and state review dates could jeopardize the JCAHO survey date and/or results.
Environment of Care	The patient safety committee has been restructured and members have been identified with a physician as chair. The committee has held it's first meeting and began development of it's charter. Would expect by 5/27 to have an approved charter with accountabilities identified. Continue to monitor Environment of Care (EOC) measures. Have hired a safety assistant to provide support in data gathering, analysis and distribution tentatively scheduled to start 5/9. Continue to recruit for an experienced safety officer. Evaluation of the processes to prevent infant abduction to be scheduled and completed within the next 3 weeks.
Facilities Management	There continues to be changes to the training work plan. The refurbishment work plan should be further along by the next update.
Materials Management	A draft of the Medical Products and Supplies Evaluation Committee has been prepared. Completing planning for the Online Requisitioning (OLR) implementation, including identification of necessary hard/software and local implementation schedule. Implementation is targeted for the end of FY04/05. There continue to be heightened efforts to recruit vacancies.
Contracted Services (Respiratory)	Instruction of the "Ventilator Management Course" to complete the RN training for Med/Surg units continues. Performance Measurements were revised and approved. The development of a ventilator weaning protocol is on-track currently finalizing documentation, protocol, and standing orders. Anticipate that workplan tasks will remain on schedule for pilot patient implementation early June 2005 with full implementation by due date of 6/30.
Contracted Services (Dietary)	Overall the action steps have been completed on target and the work plan is on schedule.
Contracted Services (Security)	Overall the action steps have been completed on target and the work plan is on schedule.

King/Drew Medical Center Workplan Implementation Summary by Initiative

County of Los Angeles Department of Health Services

Update Through: 4/29/05

Initiative	Overall Progress Update
Communications	A formalized PR Plan for the medical center was submitted to senior management for review/approval to build positive visibility for KDMC. Currently assessing staffing resources for implementation of programs included in the Plan and it may need to be scaled down. The Communications Office successfully created a new website for the Hospital Advisory Board (HAB), including the delivery of all content, design, and coordination with the DHS informatics team. A release was distributed on the stellar accreditation of the KDMC Pathology Department CAP review and will distribute another release on the nurse recruitment effort in May. We continue to receive positive internal feedback on the employee newsletter (3000 copies distributed campus-wide each month) which now includes a monthly status report on JCAHO and concrete steps employees must take to regain accreditation. The Communications office handled multiple print/broadcast media requests during April related to articles published by the Times and coordinated effective response. The scheduled employee Q&A session for April was moved to May to accommodate other admin priorities.
Case Management and Utilization	We received final approval for our Case Manager job description with commensurate designation for salary. This recognition should improve our efforts to sustain our current nurses and move forward with some initiatives that have been stalled for staffing issues. LOS data by MDC and DRG is now available and will being trending. Will identify appropriate physician groups/ forums to share data. Evaluating interdisciplinary planning round processes to roll out across med/surg units, including the evaluation of processes to transfer chronic ventilator patients to other facilities.
Capacity and Throughput	Initial interviews for Patient Placement Coordinator are completed. The most qualified applicants will be given a second interview and selection is expected by June 05. Revised schedules for housekeeping staff, to better meet bed turnaround in late afternoon. Early discharge campaign has not yet begun. Need to invigorate the effort revising the workplan action steps and accountabilities to best achieve improved performance.
Physical Therapy	Four of the recommendations have been completed. Performance measures have been identified and are being tracked. Clinical outcomes established for hip fractures, total knee and hip arthoplasty. Implementation of the clinical outcomes will occur 5/1. Actively recruiting to fill the vacant positions.
Emergency Services	ED volume has increased over the last two week period. The ED has experienced faster response times from consulting services resulting in quicker disposition times. There has also been an increase in attending physician presence in the ED from all services. We have identified and are tracking achievement of key performance measures including length of stay and diversion. New triage protocols have been implemented including a 5 level acuity system.
Perioperative Services	OR Governance Committee met 4/19 and unanimously ratified the revised OR Scheduling Policy & Procedures. Communication concerning this document to be sent from CEO, CMO, Chair and Vice-Chair of OR Governance to all MDs (revised policy will be attached). Communication plan will include posting copies of policy throughout Perioperative Services, OR staff inservice (4/29) and one-on-one conversations with stakeholders. Policy highlights: no more than 60% of prime time will be blocked, service blocks only, consequences for surgeon lateness established. Began pilot of virtual preprocedure interview tool. Identified radiology needs in OR renovations. Conducted in-depth OR staff inservice on arthroscopic equipment.
Med Admin - Clinical Programs and Medical Departments	Physician Manager training session was presented to 30 physician managers; topics included HR policies, performance improvement and disciplinary procedures, management of staff time (benefits, FMLA), performance reviews. A second session to cover the Physician's Role in Regulatory Compliance (ACGME, JCAHO, CMS) is scheduled in May. On-going meetings with HR to facilitate identification, management and resolution of HR issues re physicians with steady progress. Presentation to the PSA Executive regarding Physician Professionalism and the challenges we face. Follow-up discussions in process. Active participation in peer review meetings in several departments, modeling rigorous quality-based case review.

King/Drew Medical Center Workplan Implementation
Summary by Initiative

County of Los Angeles Department of Health Services

Update Through: 4/29/05

Initiative	Overall Progress Update
Med Admin - Medical Staff Affairs	Residency supervision prerogative requirements by specialty input into Cactus the per review database. Final review and reconciliation across departments in process. Revised residency supervision policy distributed to PSA Exec last week, for review and action at the next committee meeting (May). A streamlined physician review process was developed along with appropriate forms, and department and division physician leaders were trained. Physician reviews are now in process with target completion date of 4/3. A database was developed to integrate results of RCA's, case reviews, roundtables, and peer reviews by physician for assessment on an on-going basis and at the time of performance review and/or credentialing. Data will begin to be loaded shortly. Meeting for integration of peer review, RM/PI data base schedule for first week of May.
Med Admin - Quality, Performance Improvement, Utilization and Case Management	Formation of the Quality Oversight Committee addressed at the most recent Hospital Advisory Board meeting. Membership identified. Work in progress with County counsel to amend bylaws to permit revision of IOP Committees into overall structure for Hospital Quality Management Committee. Case review with individual departments being completed as part of clinical assistance team rounds and case review.
Med Admin - Administrative Issues / Medical Admin	Comprehensive KDMC On Call list developed and circulated as of 4/15, with simplified instructions. The schedule will be routinely audited for accuracy and responsiveness and results reported to appropriate Chiefs. Review of admin support by department in process.
Nursing Services - overall	Clinical Assistance Teams rounding on units interacting with physicians, charge nurses and staff to assist in clinical problem solving. This includes review of documentation, assistance with difficult patients who are experiencing a change in a level of care, and questions staff may have in accessing the chain of command to ensure patient safety. The Physician/RN teams will: 1) Assess appropriate patient placement utilizing newly accepted levels of care; 2) Expedite bed flow while identifying barriers; 3) Identify patients with changing levels of care and ensuring proper placement while teaching staff how to problem solve and move patient quickly; 4) Round with physicians and nurses to identify who is in charge of the patient; 5) Review documentation with both the nurses and physicians, teaching them how to improve any charting utilizing a "just in time" methodology; 6) Evaluate if physicians and nurses know the patient's plan of care; 7) Assess if nurses and physicians can easily articulate the call schedules and chain of command, including when they would use them; 8) Ensure that consults are promptly and appropriately generated; 9) Reinforce appropriate expectations of the staff for physician response; 10) Identify issues with ancillary services and encourage staff to make recommendations for improvements; 11) Identify gaps in staffing, coverage, skill level, competency, resources; 12) Evaluate response/competency levels in all code situations: blue, purple, "9" and identify areas for improvement; 13) Test all on call schedules to ensure clarity: physician/nursing supervisor/AOD and train staff how to appropriately contact appropriate resource; 14) Train staff in event notification process and encourage non-punitive reporting to ensure patient safety and improvement and 15) Review monitor settings and alarm parameters with staff. Issues that require policy development and changes will be identified and sent to the Executive Cabinet for assignment to designated ad hoc group. Ten AEDs and crash carts ordered and due to arrive 6/12 for the clinics. Monitors for telemetry, ICU, CCU and ED in purchasing process. Bathroom 'squad' in place on the telemetry unit until new monitors arrive. Interview Day for recruiting KDMS nurses 5/11. Instituted "immediate interview response" phone chain so every potential nursing candidate is interviewed immediately. First OB Joint Practice Meeting 4/27. Initiated new guidelines for submitting nursing staffing schedules requiring approval by Directors and the CNO. Planning separate orientation program to fast-tack travelers into KDMC. Have identified vacancies required for inpatients and placed order through agencies. Instituted new approval process for initiating and canceling traveler requests. Revising code blue policy based on feedback from CAT teams and Nursing Supervisor input. Finalized nursing performance measures.
Psychiatric Services - overall	Restraint training has started for all clinical staff working in the acute areas. A triage team has been formulated. Psychiatric and Pediatric Services have come to agreement that minors ages 5-13 will be housed in Pediatrics until disposition. This will be effective 6/1 providing that necessary environmental concerns are resolved. Adding additional recommendation related to inpatient length of stay reduction.

King/Drew Medical Center Workplan Implementation
Summary by Initiative

County of Los Angeles Department of Health Services

Update Through: 4/29/05

Initiative	Overall Progress Update
Information Technology - overall	The IT Group continues to meet every other week to review to review outstanding IS needs/requests, IS-related Recommendations and IS-related Action Steps from other initiatives and implementations that may require DHS' intervention. A week-long meeting is scheduled for May to plan out the GE PIS cluster installation. ORSOS has a signed PO in process. ANSOS software/hardware PO has been signed the hardware has been delivered. A database administrator is being recruited to complete the transition work. Developing a local implementation plan for Online Requisitioning targeting implementation 7/05. COGNOS software will be used for managing the performance measures of the KDMC Implementation plan. Training is scheduled May 2-11 for KDMC IT and related staff. PLATO software has been recommended/approved for clinical pertinence tracking for JCAHO preparation. Recruitment of IT staff is very slow and many candidates have elected not to come to KDMC at this time. 10 total vacancies, 1 filled this period. Two additional contract programmers approved for hire via QuadraMed Contract, 1 contract staff started effective 4/25.
Health Information Management - overall	Completed customer awareness for all HIM employees. Completed skills assessments of all HIM managers. Met with the Local 660 to representatives to discuss CCS and CTR training programs. Clinical pertinence criteria has been developed for inpatient, psychiatric inpatient and Emergency Departments. RNs have been identified for Documentation Improvement/Clinical Pertinence review program - 6 RNs have been scheduled to begin training to begin 5/3. Critical Clinical Incident Program is in place and database has been developed to track issues. General Medicine and Orthopedic clinics were selected to roll out the new scheduling system and eliminate current block scheduling and improved record control programs. Performance measures for the medical audit was completed and a standard report can now be generated in the HIM Access database.
Human Resources - overall	Outstanding personnel action requests and reminders on the completion of timely PE's continues to be a subject matter at the weekly KDMC Senior Management meetings. Ongoing various administrative and personnel related trainings have been provided to KDMC managers and staff. Performance management continues to work with Navigant and KDMC management on timely administrative actions of subordinate employees. Recruitment of key senior management positions continues with resumes and applications referred to Navigant for review and recommendations. Regulatory compliance continues to meet twice a month to ensure processes are coordinated and action is being taken for the facility to be in compliance with the management of Human Resources.
Radiology	New Interim Director appointed. Radiology physician coverage continues to be day to day. Several opportunities being explored for enhanced teleradiology services. Efforts being made to improve department efficiency by reduction of contract clerical and technical personnel, and redistribution of clinical responsibilities. Several recent efforts have resulted in improved throughput of ED patients.
Laboratory/Pathology	Consolidated Therapeutic Drug Monitoring and other tests to enhance test menus. Initiated a 'microbiology clinic month' of training for evening and night shift staff to enhance their clinical expertise with spinal fluids. Began to distribute physician satisfaction surveys. Continued a series of working meetings with the ED to improve processes. Initiated a phlebotomy program with the ED to reduce STAT turn around time and reduce specimen rejections. Officially announced the availability of phlebotomy coverage 24/7. Completed evaluations to initiate an immunohistochemistry department with a target go live date of 5/2 improving technical excellence, while reducing send out test cost. Held multi-disciplinary discussions to revamp the distribution of completed laboratory test results to physicians and gained initial support. Gained the Medical Director's support, and ED leadership, to revamp the critical test result notification policy and process. Initiated an immediate training program for nurses collecting blood specimens.
Pharmacy	Security cameras ordered to be powered down by Local 660 (done 04/21) meeting scheduled for 04/28 to discuss cameras. McKesson P2000 upgrade to begin Sunday, 05/01. Antimicrobial training for pharmacists started 04/21. Re-assessment to be done in May. Announcement of Amy Gutierrez promotion to DHS Director of Pharmacy made at county level 04/27, she will continue to provide full time coverage until successful recruitment takes place. Outsourcing RFQ in process. Awaiting proposal from three agencies that supply interim DOPs.
Cardiology	Finalization and initiation of the implementation of the work plan.
Neuroscience	Finalization and initiation of the implementation of the work plan.
Ambulatory Services - overall	Initial workplan developed. Further revisions with KDMC leadership need to be made. Accountabilities for implementation need to be established.
Programs & Services - overall	Initial draft of Recommendations to be reviewed and revised with action step, timelines and accountabilities established.